

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2915

## CERTIFICATE OF DEATH

02908

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>                             |  |
| c. LENGTH OF STAY IN 1b <u>3 yrs</u>   |  | d. STREET ADDRESS <u>Home</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>                 |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>C.</u> Last <u>Ashby</u>                 |                               | 4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>   |                                       |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 7, 1886</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Va.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?   |                                       |

|   |   |
|---|---|
| 13. FATHER'S NAME <u>Turner H Ashby</u> | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> |
|---|---|

|  |  |  |
|--|--|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>221-09-7615</u> | 17. INFORMANT Address <u>Mrs Vernon Ashby, Prince Frederick Md</u> |
|--|--|--|

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

|   |  |   |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|---|--|---|

|  |  |  |                                      |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

|   |                              |
|---|------------------------------|
| 21. I certify that I attended the deceased from <u>3 Mar</u> , 19 <u>58</u> , to <u>12 Mar</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Mar</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above. |                              |
| ACTUAL SIGNATURE <u>G. J. Weems</u>   | DATE SIGNED <u>12 Mar 59</u> |
| ADDRESS (Street, city or town, state) <u>Huntingtown, Md</u>  |                              |
| PHYSICIAN'S NAME (Type) <u>G. J. Weems</u>  |                              |

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF <u>3-15-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Thesley</u> | 22d. LOCATION (City, town, or county) (State) <u>Prince Frederick Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>Quinn's Md</u> |                                  | 24a. REC'D BY REGISTRAR <u>DATE MAR 16 '59</u>    | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>                        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

DECEASED

DOE IN NEW YORK

Blank form with horizontal lines for text entry.

2916

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Prince Frederick</b>             |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert County Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Francis Henry Digges</b>  |  |   |  | 4. DATE OF DEATH <b>March 3 19 59</b>  |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Feb. 28, 1877</b>                                  |  |
| 9. AGE (In years last birthday) <b>82</b> yrs.   |  | IF UNDER 1 YEAR                                     |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Doctor</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICAL</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |
| 13. FATHER'S NAME<br><b>Charles Claude Digges</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Emily Brent</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>?</b>                 |  | 17. INFORMANT<br><b>Nina Bond Digges, Prince Frederick, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral accident</b>   |  |   |  |  |  |  |  |
| 442X DUE TO  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  |  |  |  |
| (b) <b>Hypertensive C V R disease</b>  |  |   |  |  |  |  |  |
| (c)  |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>8 Aug 19 58</b> to <b>3 Mar 19 59</b> that I last saw the deceased alive on <b>2 Mar 19 59</b> , and that death occurred at <b>7 10 A. M.</b> from the causes and on the date stated above. |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>G. Weems</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>Huntingtown, Md.</b>  |  |  |  |
| DATE SIGNED <b>3/3/59</b>  |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. George J. Weems</b>   |  |   |  | Huntingtown, Md.   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF                                   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| <b>Burial</b>  |  | <b>Mar 5, 19 59</b>                                 |  | <b>St. Paul's Cemetery</b>   |  | <b>Prince Frederick, Md</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>A. A. Hackness &amp; Son - Mutual, Md</b>   |  |   |  | 24. REC'D BY REGISTRAR<br>DATE <b>MAR 5 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

|                                   |  |                                   |  |
|-----------------------------------|--|-----------------------------------|--|
| <p>1. Name of deceased</p>        |  | <p>2. Sex</p>                     |  |
| <p>3. Date of birth</p>           |  | <p>4. Place of birth</p>          |  |
| <p>5. Date of death</p>           |  | <p>6. Place of death</p>          |  |
| <p>7. Cause of death</p>          |  | <p>8. Manner of death</p>         |  |
| <p>9. Signature of physician</p>  |  | <p>10. Signature of registrar</p> |  |
| <p>11. Signature of informant</p> |  | <p>12. Signature of witness</p>   |  |

2917

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                       |  |   |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cabret</u> MARYLAND  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chicot</u>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chicot</u>   |   |
| c. LENGTH OF STAY IN 1b <u>Life</u>  |                                       | d. STREET ADDRESS <u>1</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elnora</u> Middle <u>Frances</u> Last <u>Dixon</u>   |                                       | 4. DATE OF DEATH<br>Month <u>Mar.</u> Day <u>1</u> Year <u>1957</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>             | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 8, 1878</u>  |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |                                       | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Chicot, Ind</u>   |                                       | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>William H. Dodson</u>   |                                       | 14. MOTHER'S MAIDEN NAME <u>Laura Saunders</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>  |                                       | 16. SOCIAL SECURITY NO. <u>no</u>  |   |
| 17. INFORMANT <u>Clara M. Dixon - Chicot - Cabret Co - Ind.</u>  |                                       | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration</u><br>DUE TO (c) |                                       | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                       |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>58</u> , to <u>March 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>55</u> , and that death occurred at <u>16</u> M. from the causes and on the date stated above.   |                                       |  |   |
| ACTUAL SIGNATURE <u>R de Villarreal</u> M.D.   |                                       | ADDRESS (Street, city or town, state) <u>St Leonard</u> DATE SIGNED <u>3/3/55</u>  |   |
| PHYSICIAN'S NAME (Type) <u>R de VILLARREAL</u>   |                                       | <u>ST. LEONARD, MD.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>Mar. 4, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Chicot Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Chicot, Cabret Co - Ind.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Harkness &amp; Son - Mutual, Ind.</u>  |                                       | 24a. REC'D BY REGISTRAR <u>Mar 5 59</u> DATE   |   |
|  |                                       | 24b. REGISTRAR'S SIGNATURE <u>Ernest S. Hanna</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







CERTIFICATE OF DEATH

|   |  |
|---|--|
| <p>1. Name of deceased: _____</p>               |  |
| <p>2. Sex: _____</p>                            |  |
| <p>3. Age: _____</p>                            |  |
| <p>4. Date of death: _____</p>                  |  |
| <p>5. Place of death: _____</p>                 |  |
| <p>6. Cause of death: _____</p>                 |  |
| <p>7. Signature of physician: _____</p>         |  |
| <p>8. Signature of registrar: _____</p>         |  |
| <p>9. Signature of informant: _____</p>         |  |
| <p>10. Signature of witness: _____</p>          |  |
| <p>11. Signature of funeral director: _____</p> |  |
| <p>12. Signature of undertaker: _____</p>       |  |
| <p>13. Signature of cemetery: _____</p>         |  |
| <p>14. Signature of burial: _____</p>           |  |
| <p>15. Signature of interment: _____</p>        |  |
| <p>16. Signature of cremation: _____</p>        |  |
| <p>17. Signature of other: _____</p>            |  |
| <p>18. Signature of other: _____</p>            |  |
| <p>19. Signature of other: _____</p>            |  |
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| <p>22. Signature of other: _____</p>            |  |
| <p>23. Signature of other: _____</p>            |  |
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| <p>26. Signature of other: _____</p>            |  |
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| <p>58. Signature of other: _____</p>            |  |
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| <p>61. Signature of other: _____</p>            |  |
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| <p>81. Signature of other: _____</p>            |  |
| <p>82. Signature of other: _____</p>            |  |
| <p>83. Signature of other: _____</p>            |  |
| <p>84. Signature of other: _____</p>            |  |
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| <p>98. Signature of other: _____</p>            |  |
| <p>99. Signature of other: _____</p>            |  |
| <p>100. Signature of other: _____</p>           |  |



2919

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>St. Leonards</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert County Hospital</b>   |                                     | d. STREET ADDRESS<br><b>1</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Catherine</b> Middle <b>E.</b> Last <b>Grover</b>  |                                     | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>25</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 8, 1918</b>   |
| 9. AGE (In years last birthday)<br><b>40 yrs.</b>  |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Oliver Buckler</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Blanche Fowler</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)   |                                     | 16. SOCIAL SECURITY NO.<br><b>212-24-2543</b>  |   |
| 17. INFORMANT<br><b>Wilson B. Grover, St. Leonards Md.</b>   |                                     | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatous</b><br><b>171X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ca of cervix &amp; uterus</b> DUE TO<br>(c) <b>1 year</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>58</b> , to <b>3/25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/25</b> , 19 <b>59</b> , and that death occurred at <b>7:10</b> M, from the causes and on the date stated above.   |                                     |  |   |
| ACTUAL SIGNATURE<br><b>Roe Villarreal</b>  |                                     | DATE SIGNED<br><b>3/25/59</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>ROE VILLARREAL MD</b>  |                                     | ADDRESS (Street, city or town, state)<br><b>St Leonards, Md</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>3/28/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>COMMUNITY CHURCH CEM.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>LUSBY - CALVERT CO. - MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>O. O. Warkentin &amp; Son - Funeral, Inc.</b>   |                                     | 24. REC'D BY REGISTRAR<br>DATE <b>MAR 30 59</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |                                     |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE

DATE

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

2923

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>                                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <u>Edgar V Kopp</u> First Middle Last   |  | 4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1959</u>  |   |
| 5. SEX <u>7</u>   | 6. COLOR OR RACE <u>W</u>              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 22, '75</u>   |
| 9. AGE (In years, months, days, hours, minutes) <u>83</u> yrs   |  | 10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Minutes _____   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |   |
| 13. FATHER'S NAME <u>George Collins</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Catherine R. Cocker</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>No</u>   |   |
| 17. INFORMANT <u>Glenn Kopp</u> Address <u>Solomons Md</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aged</u><br>DUE TO (c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been up on beam when she was walking across floor and fell off and was saved with a chain</u>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour, o. m. <u>8 p.m. 3/24/59</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, shop, etc.) <u>Friends home</u>  |  | 20f. (City or town) <u>Solomons</u> (County) <u>Calvert</u> (State) <u>Md</u>   |   |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.   |  | DATE SIGNED <u>3/24/59</u>  |   |
| PHYSICIAN'S NAME (Type) <u>H. W. Ward</u>   |  | <u>O. W. AGG</u> MD   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Mar. 26, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>  | 22d. LOCATION (City, town, or county) (State) <u>Solomons - Calvert Co. - Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackman &amp; Son - 7 Mutual, Md</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>  |   |
|   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2920  
CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Prince Frederick</u>   |  |  |  | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Calvert County Hospital</u>  |  |  |  | 1 d STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>(A)</u> <u>Mackall</u>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>March</u> <u>17</u> <u>1959</u>   |  |  |  |
| 5 SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>Negro</u>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-17-59</u>   |  |
| 9. AGE (In years last birthday) yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY        |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Cornelius Mackall</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Ella Mae Parker</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)  |  | 16. SOCIAL SECURITY NO                   |  | 17. INFORMANT<br><u>Ella Mae Mackall</u>  |  | Address<br><u>Prince Frederick</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prenatal (4 months)</u><br><u>776X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                     |  |
| 20f. (City or town) (County) (State)  |  |  |  | 20g. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>59</u> , to <u>3/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>5th Ave</u> DATE SIGNED <u>3/18</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Robert de Villarreal, MD.</u>  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF<br><u>3-18, 59</u>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Pottuxent</u>  |  | 22d. LOCATION (City, town or county) (State)<br><u>Huntingtown</u> <u>3/18</u>             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>F. E. Sennell Prince Frederick</u>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 23 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

2021

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Prince Frederick</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Prince Frederick</u>                                      |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Calvert County Hospital</u>   |                                  | 1 d. STREET ADDRESS<br><u>1</u>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>B</u> Middle <u>Mackall</u> Last <u>Mackall</u>   |                                  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>17</u> Year <u>19</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-17-58</u>                         |
| 9. AGE (In years last birthday)<br><u>10</u>  |                                  | IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
|   |                                  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |                                  |  |  |
| 13. FATHER'S NAME<br><u>Cornelius Mackall</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Ella Mae Parker</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO   |  |
|   |                                  | 17. INFORMANT<br><u>Ella Mae Mackall Prince Frederick</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction (4th month)</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 hour</u><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> Month <u>3</u> Day <u>17</u> Year <u>1959</u><br>a. m. p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>3/17</u> 19 <u>59</u> , to <u>3/17</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3/17</u> 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE<br><u>Robert de V. Verreault, M.D.</u>   |                                  | DATE SIGNED<br><u>3/18/59</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>Robert de V. Verreault, M.D.</u>  |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>3-18-59 Potomac</u>   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Huntingtown</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>P. E. Sewell Prince Frederick</u>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 23 '59</u>  |  |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2022

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |                                 |  |   |  |   |  |
|---|--|---------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND  |  |                                 |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>  |  |                                 |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>                                      |  |   |  |
| c. LENGTH OF STAY IN 1b   |  |                                 |  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>                                   |  |   |  |
| d. STREET ADDRESS <u>1</u>  |  |                                 |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>C</u> Middle <u>Mackall</u> Last <u>Mackall</u>  |  |                                 |  | 4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>  |  |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>Negro</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>3-17-59</u>                                     |  |
| 9. AGE (In years last birthday) yrs <u>5</u>  |  | IF UNDER 1 YEAR Months <u>5</u> |  | IF UNDER 24 HRS Days <u>5</u> Hours <u>5</u> Min. <u>5</u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                                 |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>           |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |                                 |  |   |  |   |  |
| 13. FATHER'S NAME <u>Cornelius Mackall</u>  |  |                                 |  | 14. MOTHER'S MAIDEN NAME <u>Ella Mae Parker</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)   |  |                                 |  | 16. SOCIAL SECURITY NO  |  | 17. INFORMANT Address <u>Ella Mae Mackall Prince Frederick</u>      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |                                 |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Premature (4th m)</u>  |  |                                 |  |   |  |   |  |
| DUE TO  |  |                                 |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 hour</u>  |  |                                 |  |   |  |   |  |
| DUE TO (c)  |  |                                 |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                 |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                 |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                 |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY Hour <u>19</u> Month <u>3</u> Day <u>17</u> Year <u>1959</u>  |  |                                 |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>               |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                                 |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>59</u> , to <u>3/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>59</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above. |  |                                 |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Robert de Villareal</u> M.D.  |  |                                 |  | ADDRESS (Street, city or town, state) <u>5th Avenue</u> DATE SIGNED <u>3/18</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Robert de Villareal, MD</u>  |  |                                 |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-18-59</u>  |  | 22b. DATE THEREOF               |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Patuxent</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Huntingtown Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Prince Frederick</u> ADDRESS   |  |                                 |  | 24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2924

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                              |   |   |   |   |  |   |
|--|------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u> MARYLAND   |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Seabrook</u>  |                              |   | c. LENGTH OF STAY IN 1b<br><u>Life</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Seabrook</u> |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                              |   |   | d. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Northam</u> Last <u>Northam</u>  |                              |   |   | 4. DATE OF DEATH<br>Month <u>Mar</u> Day <u>16</u> Year <u>1959</u>   |   |  |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 4 1881</u>  |   | 9. AGE (In years last birthday) yrs. <u>77</u>  | 10. IF UNDER 1 YEAR IF UNDER 74 HRS<br>Months Days Hours Min.                                  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self-employed</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Boat building</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Shale Island, S.C.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>John Northam</u>   |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Esther S. Northam</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.<br><u>420-11-1111</u>   |   | 17. INFORMANT<br><u>Mrs. Esther C. Northam</u> Address <u>Seabrook, Calvert Co., Md.</u>  |   |  |   |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)}<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u><br>DUE TO (c)   |                              |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                              |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                              |  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>6 Mar</u> 19 <u>59</u> to <u>10 Mar</u> 19 <u>59</u> , that I last saw the deceased alive on <u>9 Mar</u> 19 <u>59</u> , and that death occurred at <u>5 A</u> M, from the copies and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>W. J. Weems</u> M.D. <u>Huntingtown, 10 Mar 59</u><br>PHYSICIAN'S NAME (Type) <u>W. J. WEEMS</u> <u>420.11-1111</u> |                              |   |   |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State)  |   |
| <u>Buried</u>  |                              | <u>Mar 16 1959</u>  |   | <u>Mar. Home Chapel Inc.</u>  |   | <u>Seabrook Calvert Co - Md</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |                              |   |   | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 16 '59</u>  |   |
| <u>Arthur S. Kinne</u>   |                              |   |   | <u>Seabrook, Calvert Co., Md</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kinne</u>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





2925

## CERTIFICATE OF DEATH

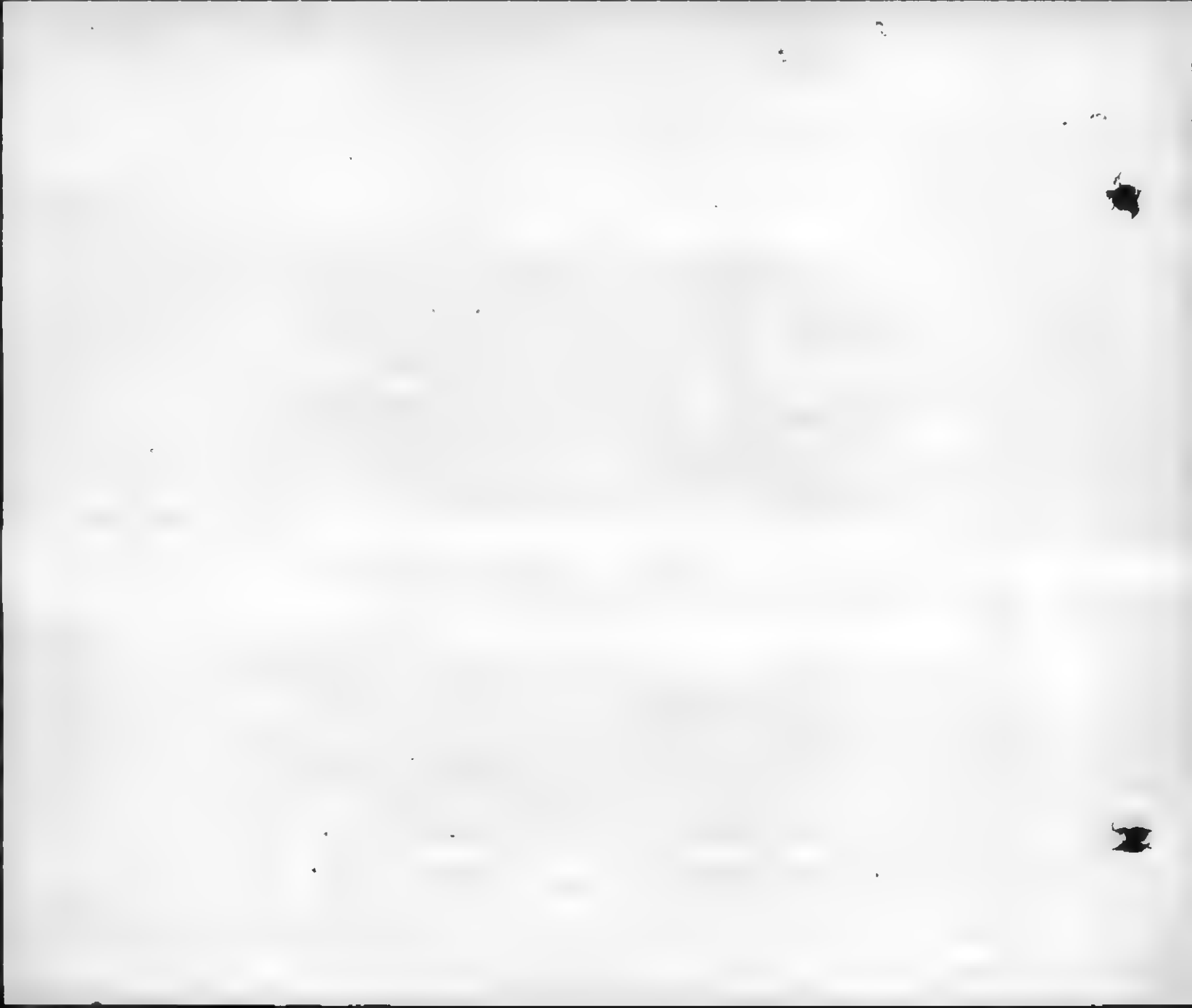
Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Calvert</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b><br>c. LENGTH OF STAY IN 1b<br><i>life</i><br>d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Calvert County Hospital</b>   |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>STATE <b>Maryland</b><br>b. COUNTY <b>Calvert</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b><br>d. STREET ADDRESS<br><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>James Franklin</b><br>First Middle Last  |   | 4. DATE OF DEATH<br><b>March 13</b><br>Month Day Year <b>1959</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Sept. 10, 1912</b><br>9. AGE (In years last birthday) <b>46</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sold junk iron</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Andrew Johnson</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Julia Chase Hardtman</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b><br>(If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO<br><b>217-09-5694</b>   |   |
| 17. INFORMANT<br><b>Eloise Parran, Prince Frederick, Md.</b><br>Address  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br><b>41X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>2 Nov 1958</b> to <b>12 Nov 1959</b> , that I last saw the deceased alive on <b>10 Nov 1959</b> , and that death occurred at <b>3:45 A</b> M, from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>Huntingtown, Md.</b> DATE SIGNED <b>3/13/59</b>  |   |  |   |
| ACTUAL SIGNATURE <b>George J. Weems</b> M.D.   |   | Huntingtown, Md.   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. George J. Weems</b>   |   | Huntingtown, Md.   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>   | 22b. DATE THEREOF<br><b>Mar 16, 59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bible-way Church-C</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>65 Road, Pr. Fred. Md.</b>              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Berry - Huntingtown, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 18 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02918

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Cabot</i><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Md.</i><br>b. COUNTY <i>Cabot</i>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Prince Frederick</i>   |  | c. LENGTH OF STAY IN 1b<br><i>2 weeks</i>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Cabot Co. H. H.</i>  |  | e. STREET ADDRESS<br><i>701</i>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>Owings, H. Russell</i>  |  | 4. DATE OF DEATH<br>Month <i>3</i> Day <i>10</i> Year <i>1959</i>   |  |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>5/6/89</i>  |
| 9. AGE (In years last birthday)<br><i>69</i> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <i>0</i> Days <i>0</i>  | 11. IF UNDER 24 HRS.<br>Hours <i>0</i> Min. <i>0</i>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Asst. of Assessment</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Cabot Co.</i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Md.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Harry P. Owings</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Hattie Lansing</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>yes</i>  |  | 16. SOCIAL SECURITY NO.<br><i>WW# 1</i>   |  |
| 17. INFORMANT<br><i>Mrs. Russell Owings, Owings Ind</i>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br>22.2 DUE TO <i>Alcohol poisoning</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Alcohol poisoning</i><br>DUE TO (c)   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been drinking. Brought to hospital. Was not in chair.</i>  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)<br><i>When he took new deep breaths and died</i>               |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><i>9:55 a.m. 3 10 59</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>Home</i>   | 20f. (City or town), (County), (State)<br><i>Cabot Md</i>                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |
| ACTUAL SIGNATURE<br><i>H. W. Ward</i>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><i>H. W. WARD</i>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED<br><i>3/10/59</i>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Buried</i>  | 22b. DATE THEREOF<br><i>Mar 12, 1959</i>   | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Friendship Methodist</i>   | 22d. LOCATION (City, town, or county) (State)<br><i>Prince Georges Co. A.A. Camp Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>G. A. Harrison &amp; Son - Inc. Inc., Inc.</i>   |  | 24. REC'D BY REGISTRAR<br>DATE <i>MAR 16 '59</i>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hines</i>  |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar plus 7a burial/cremation, or removal.



2927

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Calvert</i> MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>  |                                 | c. LENGTH OF STAY IN 1b <i>109</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hospital</i>  |                                 | d. STREET ADDRESS <i>Ches. Beach 109</i>   |  |
| 3. NAME OF DECEASED (Type or print) <i>John F. Schrimmer</i>  |                                 | 4. DATE OF DEATH <i>3</i> Month <i>3</i> Day <i>3</i> Year <i>1959</i>   |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>W</i>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/11/74</i>                                      |
| 9. AGE (In years and birthday) <i>84</i> yrs.   |                                 | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <i>Wash DC</i>   |  |
| 11. BIRTHPLACE (State or foreign country)   |                                 | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <i>Lawrence Schrimmer</i>   |                                 | 14. MOTHER'S MAIDEN NAME <i>Harriet McMonera</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>  |                                 | 16. SOCIAL SECURITY NO. <i>Mr. John F. Schrimmer Ches. Beach 109</i>   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiovascular renal disease</i><br><i>481X</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Age and atherosclerosis</i><br>DUE TO (c) |                                 | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured hip</i>  |                                 | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home</i>   |  |
| 20c. TIME OF INJURY Month, Day, Year <i>3</i> Hour <i>p. m.</i> <i>10/11/58</i>   |                                 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>  |                                 | 20f. (City or town) <i>Ches. Beach Calvert</i> (County) <i>Calvert</i> (State) <i>MD</i>   |  |
| 21. I certify that I attended the deceased from <i>10/11/58</i> to <i>3/13/59</i> , that I last saw the deceased alive on <i>3/12/59</i> , and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.   |                                 | ADDRESS (Street, city or town, state) <i>Ches. Beach 109</i> DATE SIGNED <i>3/13/59</i>  |  |
| ACTUAL SIGNATURE <i>H W Ward</i> M.D. <i>Owney</i>  |                                 | PHYSICIAN'S NAME (Type) <i>H W Ward</i>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 22b. DATE THEREOF <i>3-6-59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood</i>   | 22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Washington D.C.</i> ADDRESS  |                                 | 24a. REC'D BY REGISTRAR <i>MAR 6 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                   |  |                               |  |                               |  |                                |  |
|-----------------------------------|--|-------------------------------|--|-------------------------------|--|--------------------------------|--|
| 1. Name of deceased               |  | 2. Sex                        |  | 3. Age                        |  | 4. Date of death               |  |
| 5. Place of death                 |  | 6. Cause of death             |  | 7. Manner of death            |  | 8. Signature of physician      |  |
| 9. Signature of registrar         |  | 10. Signature of informant    |  | 11. Signature of witness      |  | 12. Signature of coroner       |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker   |  | 15. Signature of cemetery     |  | 16. Signature of burial place  |  |
| 17. Signature of burial place     |  | 18. Signature of burial place |  | 19. Signature of burial place |  | 20. Signature of burial place  |  |
| 21. Signature of burial place     |  | 22. Signature of burial place |  | 23. Signature of burial place |  | 24. Signature of burial place  |  |
| 25. Signature of burial place     |  | 26. Signature of burial place |  | 27. Signature of burial place |  | 28. Signature of burial place  |  |
| 29. Signature of burial place     |  | 30. Signature of burial place |  | 31. Signature of burial place |  | 32. Signature of burial place  |  |
| 33. Signature of burial place     |  | 34. Signature of burial place |  | 35. Signature of burial place |  | 36. Signature of burial place  |  |
| 37. Signature of burial place     |  | 38. Signature of burial place |  | 39. Signature of burial place |  | 40. Signature of burial place  |  |
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| 45. Signature of burial place     |  | 46. Signature of burial place |  | 47. Signature of burial place |  | 48. Signature of burial place  |  |
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G241, 4/10/59 fcy

## CERTIFICATE OF DEATH

Reg. Dist. No.

02920

2028

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cabot Co.</b> <span style="float: right;">MARYLAND</span>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Charles</b></span> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marshall Hall</b>   |  |   |  |
| c. LENGTH OF STAY IN 1b<br><b>4 month.</b>   |  |   |  | d. STREET ADDRESS<br><b>08X-2</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cabot Nursing Home</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>John W. Wilson</b> <span style="float: right;">Middle Last</span>  |  |   |  | 4. DATE OF DEATH<br>Month <b>march</b> Day <b>17</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |  | 8. DATE OF BIRTH<br><b>Approx. UNK 65 yrs. UNK</b>  |  |
| 9. AGE (In years last birthday)<br><b>UNK</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>UNK</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>UNK</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>A. M. Wilson.</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>UNK</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>UNK</b>  |  | 17. INFORMANT<br><b>Calvert Nursing Home, Prince Frederick, Md.</b>                               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio vascular renal disease</b><br>DUE TO <b>Cerebral accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs 18 hrs</b>         |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)  |  |   |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec 5</b> , 19 <b>58</b> , to <b>3/17/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/17/59</b> , 19 <b>59</b> , and that death occurred at <b>2:15 P.</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Marshall Hall, Md.</b> DATE SIGNED <b>Arthur S. Thomas</b> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>H. W. Ward</b>  |  |   |  | PHYSICIAN'S NAME (Type)<br><b>The Hunt Funeral Home, Waldorf, Md.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3-20-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Ch. Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Accokeek, Md.</b>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The Hunt Funeral Home, Waldorf, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 23 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

